STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
June 20, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Disabled American Veterans (DAV) regarding the Department of Veterans Affairs (VA) specialized programs of care for veterans suffering from severe mental illness, substance-use disorders, and homelessness. Many severely disabled and homeless veterans need and rely on VA's specialized health care services. Therefore, this issue continues to be one of our foremost concerns and is of great importance to the DAV's more than one million members and their families.

The DAV views the Veterans Health Administration's (VHA's) programs for veterans with special needs as the core of the VA health care system. Many of these specialized programs, such as those developed to treat serious mental illness, substance-use disorders, and posttraumatic stress disorder, are unmatched in excellence. Unfortunately, over the past five years there has been a continuing erosion of specialized services for veterans suffering from these severely disabling conditions.

In 1995, VHA shifted from an inpatient model of hospital-based care to a more comprehensive outpatient-based health care delivery system. This change has yielded several positive results; however, the shift to an outpatient based primary care model has had a negative effect on many of VA's specialized programs, including mental health services. Although most veterans now have better access to community-based primary care services, mental health care services are not available at many community-based outpatient clinics (CBOCs). Since the shift to outpatient-based care, there has been insufficient development throughout the VA system of necessary outpatient-based mental health services to replace the more traditional inpatient programs. The Committee on Care of Severely Chronically Mentally Ill Veterans submitted a response to a draft of the 2000 annual Capacity Report dated May 31, 2001. In its memorandum, the Committee noted that over the past decade there has been significant deinstitutionalization of seriously mentally ill (SMI) patients and that inpatient resources for these patients had been reduced by more than 50 percent. The committee reported that in 2000 "…only half [of all CBOCs] provides meaningful mental health services, varying among networks from 100 percent to 13 percent."

Congress recognized the importance of maintaining capacity for VA's specialized programs and enacted Public Law 104-262, which mandated that

> …the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of disabled veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that the overall capacity of the department to provide such services is not reduced…

It was mandated that capacity would be maintained at levels reported in fiscal year 1996. However, despite these statutory requirements to maintain its capacity to serve disabled veterans with severe mental illness, many specialized inpatient programs have been closed, cutback, or severely compromised by staff shortages or reorganization.

The Committee noted in its May 31 memorandum that capacity measures were to be determined by the number of veterans treated and the dollars expended for their care, and that capacity could only be maintained if both components were met. It also determined that the number of dollars expended was a reasonable way to monitor whether the necessary reinvestment of resources from institutional to outpatient-based care was occurring. As a final measure, the Committee noted that these figures are only meaningful if a reasonable adjustment for inflation was included.

The Committee determined that the two elements of the capacity definition were not met in the 2000 Capacity Report for PTSD, the overall SMI group, or the substance abuse population of veterans. They were met for the SMI homeless population. It noted that the 2000 report omits key information included in last year's report on inflation-adjusted dollars and uses unadjusted dollars only. Therefore, based on the data supplied in the fiscal year 2000 Capacity Report, the Committee concluded, "… that the Department is still not in compliance with the capacity provisions in Public Law 104-262." We agree with these findings.

It is essential for VHA to maintain equal access to a full continuum of mental health services across the VISNs for SMI veterans. Intensive case management is often necessary to successfully manage patients with severe mental illness on an outpatient basis. Additionally, many veterans dealing with substance abuse disorders and PTSD need a structured support system with routine monitoring by mental health care professionals. Without access to appropriate VA mental health care services, these patients may experience serious setbacks, homelessness or other related problems, and have to rely on other community resources for assistance.

Additionally, outpatient treatment programs may not always be appropriate for all veterans with specialized needs. In the past, VA was well known for its excellent programs for veterans dealing with substance-use disorders. These lengthy and intensive inpatient programs

were highly successful and helped many veterans to overcome their addictions and once again lead productive healthy lives. However, due to cutbacks, many of these programs are no longer available. Some counselors have indicated that veterans seeking treatment for substance-use disorders are at a higher risk for relapse if they do not have access to traditional long-term inpatient programs or, at the very least, intensive outpatient case management. Likewise, shifting serious chronic mentally ill veterans to primary outpatient care settings may not always relate to satisfactory care/treatment for these patients.

Resource allocation and policy decisions for specialized mental health services should be based on patient need. Unfortunately, it appears that in some cases, Network funding distribution decisions have equated to reductions in local mental health care services. Adequate funding is necessary for VHA to meet capacity mandates, to staff specialized programs with qualified individuals, and to provide quality timely care. Congressional oversight to maintain these specialized services is necessary to protect our Nation's most vulnerable veterans. Information provided in the annual Capacity Report is essential for determining the status of specialized programs within VHA. However, this is the last report mandated by Public Law 104-262. Because the information contained in the Capacity Report is necessary for tracking the status of these important programs, it is the DAV's recommendation that the Secretary should continue to submit annual reports to the House and Senate Veterans' Affairs Committees for continued oversight of capacity.

Recently, the DAV became aware of deliberations within VA concerning medication treatment guidelines for veterans with schizophrenia. We are concerned that VA clinical managers are considering the adoption of a system-wide policy that may in effect restrict the clinical discretion of VA staff psychiatrists and thereby limit the treatment options for veterans with schizophrenia.

Several medications, referred to as novel anti-psychotropics, are available to treat patients with schizophrenia and have been shown to improve cognitive functioning and reduce psychotic symptoms with fewer side effects compared to traditional medications. However, costs for the newer medications vary significantly. In an attempt to manage the increased costs for these medications, guidelines were developed in VISNs 11 and 22 that in effect may restrict a physician from prescribing first-line medication that he or she deems most appropriate based on patient need. We strongly object to any policy directives that are cost-driven rather than based solely on standards of best practice. The guidelines for the use of antipsychotic medication in VISN 11 would have a physician use, "in the absence of differential efficacy data, or any other patient specific issues for the use of one medication over another, the medication with the lowest acquisition cost first." Under this policy, patients would undergo two separate trial periods on the lowest costing novel antipsychotic medications first, for up to ten weeks each. Clinical assessment of medication failure would determine whether medication change to another novel antipsychotic was indicated.

This "fail-first" policy raises a great deal of concern for the DAV. First and foremost, we do not believe that it gives clinicians full freedom to exercise their best clinical judgment in determining the needs of his or her patient without being concerned about cost. Providers would be left to consider just how serious are the side effects reported by the veteran and can they

justify use of one of the other novel medications. Secondly, it does not take into consideration that some veterans may experience delayed access to mental health care services at local facilities. This would be especially disturbing if a SMI veteran was failing on a prescribed trial of medication and does not have immediate access to follow-up care. Patients should not be subjected to various clinical trials of medication, which could lead to a psychiatric crisis or a set back in mental health status simply because of cost saving measures. A medication trial failure may result in serious consequences for the SMI patient. He or she may cause harm to themselves or others during such an event and not recover to their previous mental health status following a full-blown psychotic episode. This policy could delay effective treatment for 20 weeks or more. Clinical managers must consider if the higher acquisition cost of one novel antipsychotic over the other will be offset by other related treatment costs such as inpatient or outpatient care if the patient experiences a serious psychotic episode on an initial medication trial, as dictated by policy.

Finally, it does not take into account that individuals react differently to different types of medication and that sensitivity to side effects from antipsychotic medications differs from individual to individual. Patients rely on clinicians to choose the best possible treatment for their specific disease and individual clinical history. It is unfair to both the patient and treating physician to have to follow specified medication treatment guidelines for the treatment of schizophrenia simply as a cost saving measure. The clinician should be able to prescribe the most effective medication for the patient based on the needs of that patient, without regard to cost.

SMI veterans deserve high quality and timely access to mental health care services. These two factors should guide all decisions concerning their care at VA facilities. Guidelines for treatment of patients with schizophrenia that restrict or limit a clinician's ability to prescribe medications based solely on clinical assessment and individual needs of the patient should be abandoned. Higher costs in medications must be weighed against offsets in other treatment costs associated with inpatient or frequent outpatient mental health services associated with a medication treatment failure. Most importantly, medications that could significantly improve an SMI patient's quality of life should be available to the patient if deemed appropriate by his or her physician, without regard to cost.

Recently, Representative Bob Filner (D-CA) wrote to Secretary of Veterans Affairs Anthony J. Principi concerning this issue. He noted that an ongoing project to determine the relative safety and efficacy of anti-psychotic medication trials has been funded by Congress. He requested that VA not promulgate new schizophrenia treatment guidelines until it has received the results from the Clinical Antipsychotic Trials Intervention Effectiveness (CATIE) Project being conducted by the National Institute of Mental Health. DAV also requests that VHA immediately suspend any current medication guidelines for the treatment of schizophrenia pending the outcome of the CATIE project.

Likewise, DAV is very concerned about VA's specialized programs for veterans who are homeless. Following his appointment to Secretary of Veterans Affairs, Jesse Brown announced, "Homelessness in America is a national tragedy. And homelessness among those men and women who so honorably served our country is an even greater tragedy. The Department of

Veterans Affairs (VA) has made the fight to end homelessness among veterans a top priority." Secretary Principi has also announced that one of his top priorities will be the issue of homeless veterans and that he will establish a task force to review this issue.

It is estimated that, on any given night, approximately 275,000 veterans are homeless. Access to VA benefits and specialized services is essential for many homeless veterans to regain and hold steady employment. A comprehensive care approach, including specialized programs for mental health care and substance abuse problems, offers homeless veterans a hand up and an opportunity to break the cycle of homelessness.

Traditionally, homeless veterans have been treated in VA inpatient and domiciliary care programs. However, as VA moved toward community-based outpatient care, we began to see a decline in the number of programs and services available to address the needs of this veteran population. Unfortunately, many homeless veterans experience serious mental illness and struggle with substance abuse disorders and posttraumatic stress disorder. Addressing the needs of homeless veterans requires more than a place to stay. Specialized programs and complex care regimes are necessary to help homeless veterans rebound and move from the streets to self-sufficiency.

We need an accurate assessment from VHA as to the staffing and funding levels dedicated to homeless services in each medical center and the types of programs currently functioning to address the complex needs of the homeless veteran population. VA must tailor its health care services to meet the unique needs of homeless veterans. The Heather French Henry Homeless Veterans Assistance Act, H.R. 936, introduced by Representative Lane Evans (D-IL), provides a vehicle to begin to address those needs.

The DAV, in concert with the other *Independent Budget* veterans service organizations, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars, have previously expressed serious concerns about capacity for specialized programs in VHA. The system is experiencing serious difficulties in providing quality and timely care and the specialized services veterans need consistently nationwide.

The DAV recognizes that VA has made an effort to address problems associated with capacity of its specialized programs. But clearly, more needs to be done. VHA must honestly assess and request accurate funding levels needed to fulfill its mission of providing quality and timely specialized health care services to our Nation's most vulnerable veterans.